

Appendix I: Compendium of Unimplemented OIG Recommendations 2008

<http://www.oig.hhs.gov/publications/docs/compendium/compendium2008.pdf>

Ensure Appropriateness of Medicare Payments for Mental Health Services

Background: Section 1862(a)(1)(A) of the SSA requires all services, including mental health services, to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

Finding(s): Our reviews have indicated that claim error rates for mental health services have exceeded 34 percent, suggesting widespread problems across a variety of provider types and care settings. Our 2007 study projected that 47 percent of the mental health services allowed by Medicare in 2003 did not meet program requirements. Billing abuses involving beneficiaries who are unable to benefit from psychotherapy demonstrate a special need for enhanced program and beneficiary protections. Also, beneficiaries with mental illness sometimes do not receive all the services that they need, so that both underutilization and overutilization problems exist.

“Partial hospitalization” services, which may be provided by both hospitals and community mental health centers, have been particularly troublesome. These intensive services are designed to reduce the need for hospitalization of beneficiaries with serious mental illness. We have estimated that payment error rates for partial hospitalization in community mental health centers were as high as 92 percent. A number of these centers were terminated from the program after CMS determined that they did not meet certification requirements.

Further, miscoded and undocumented services accounted for 26 and 19 percent of all mental health services in 2003, respectively. Medically unnecessary services and services that violated the “incident to” rule each accounted for 4 percent of all mental health services in 2003. The “incident to” rule allows a physician to bill for mental health services performed by his or her staff if the services are rendered “incident to” a physician’s professional services.

SAVINGS: \$1.44 billion*

**This figure includes \$224 million for acute hospital outpatient services in 1997, \$229 million in improper payments for partial hospitalization in community mental health centers in 1997, \$57 million in improper payments for psychiatric hospital outpatient services in 1998, \$30 million in improper payments for mental health services in 1999, and \$185 million in improper payments for other mental health services in 1998 and \$718 million in improper payments in 2003.*

Recommendation(s): CMS should ensure that mental health services are medically necessary and reasonable; are accurately billed; and are ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance. Additionally, CMS should revise, expand, and reissue its 2003 Program Memorandum on Part B mental health services with an increased emphasis on proper documentation, coding, and requirements for mental health services billed “incident to.”

Status: In its comments on the draft of our October 1998 report, CMS concurred with the recommendations, noting that it had initiated some efforts to reduce unallowable payments.

CMS indicated that it was conducting site visits at community mental health centers and had terminated noncompliant providers from the Medicare program. Our work during 2006 in the area of community mental health centers indicated that there were still significant unallowable payments. In April 2008, CMS stated that it was considering changes to ensure more accurate payment policy. CMS also concurred with our recommendations to our 2007 report but noted that significant information on medical documentation requirements, including “incident to” services, is available on its Web site. We determined that guidance on documentation for evaluation and management services can be found in the “Claims Processing Manual” (Pub. 100-04, Chapter 12, section 30.6) and that specific guidance on “incident to” services can be found in the “Benefits Policy Manual” (Pub. 100-02, Chapter 15, section 60.1). We continue to recommend that CMS reissue the 2003 Program Memorandum with the additional guidance cited in our recommendations.

Report(s):

OAS-04-98-02145; issued 10/98

OAS-01-99-00507; issued 03/00

OAS-01-99-00530; issued 12/00

OEI-03-99-00130; issued 05/01

OEI-02-99-00140; issued 01/01

OAS-06-04-00076; issued 03/06

OAS-04-04-02003; issued 04/06

OEI-09-04-00220; issued 04/07

